Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST FORT WORTH
PO BOX 916063
FORT WORTH TX 76191

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-05-4703-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "The following clm paid with a 4 day per diem rate. I am requesting that the implants be paid @ cost plus 10% total cost was 3257.42 we are still owed $757.42. I am also Req that the 2 codes w/CPT codes be paid per the TX fee sch."

Letter Requesting Reconsideration of Payment dated September 27, 2004: "According to Commission Rule 134.401, ICD-9 codes ranging from 800.0 thru 959.50 shall be reimbursed at a fair and reasonable rate for the entire admission. As these codes are specifically carved out of the ACIHFG, it is our understanding that these admits are not considered at the per diem rate, or at any applicable fee schedule amounts. It is implied in the ACIHFG that although this is a trauma admission the fair and reasonable for this should be at least 75%."

Amount in Dispute: $1224.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Paid per IA WC Rules. The procedure was performed in Texas and the provider was paid per the TX WC Fee Schedule." "Paid per the Texas W/C Fee Schedule at the inpatient surgical per diem @ $1118.00 x 4 days = $4472.00 plus implants at fair and reasonable @ $2500.00, as provider did not send invoices and also no description on itemization for implants of any type. Treatment rendered does not meet the requirements of trauma category. Total payment made: $6.972.00." "Upon appeal the provider submitted invoices for implants and they were recalculated per the facilities own invoices…plus 10% cost markup = $2764.01. Also the carve outs CPT code 76375 was paid at the TX FS technical component@ $188.00. CPT code 73700 was paid per the Texas Fee Schedule technical component @ $285.00…Total payment made $7718.42."

Response Submitted by: Liberty Mutual Insurance Co., 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2004	Implants	$751.42	$0.00
May 14, 2004	CPT Code - 76375	$188.00	$0.00
May 14, 2004	CPT Code 73700	$285.00	$0.00
TOTAL		$1224.42	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on February 22, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 9, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated June 25, 2004
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.
   - Z789-Code description not given.
   - Z652-Recommendationof payment has been based on a procedure code which best describes services rendered.

   Explanation of Benefits dated July 13, 2004
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.
   - Z782-Payment reduced due to lack of wholesale invoice.
   - Z652-Recommendationof payment has been based on a procedure code which best describes services rendered.

   Explanation of Benefits dated October 26, 2004
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.
   - Z652-Recommendationof payment has been based on a procedure code which best describes services rendered.

- Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.00. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the letter requesting reconsideration that ". "It is implied in the ACIHFG that although this is a trauma admission the fair and reasonable for this should be at least 75%." Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.
3. 28 Texas Administrative Code §133.307(e)(2)(C), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." The Division notes that the requestor has listed an amount of $1224.42 as the total amount in dispute. The requestor did not list on the Table of Disputed Services the alternative stop-loss reimbursement methodology of 75% of billed charges. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under §133.307(e)(2)(C).
4. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement from the Table of Disputed Services asserts that "The following clm paid with a 4 day per diem rate. I am requesting that the implants be paid @ cost plus 10% total cost was 3257.42 we are still owed $757.42. I am also Req that the 2 codes w/CPT codes be paid per the TX fee sch."
   - The respondent submitted documentation that supports an additional payment of $746.22 was made on October 26, 2004. The breakdown of payment is: $264.01 was made on the implants; $188.00 for CPT code 76375; $285.00 for CPT code 73700; and $9.21 in interest.
   - In the alternative, the requestor is seeking additional reimbursement based upon " It is implied in the ACIHFG that although this is a trauma admission the fair and reasonable for this should be at least 75%."
   - The requestor did not list on the Table of Disputed Services or on the Letter Requesting Reconsideration the alternative amount based upon 75% of billed amount.
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per 28 Texas Administrative Code §134.401(c)(6).
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/30/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.